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ABSTRACT

This training guide was developed by the West Virginia Research and Training Center staff in response to the mandate of the Rehabilitation Act of 1973 which emphasized that vocational rehabilitation caseloads must contain a large proportion of severely handicapped clients. It is designed to assist the rehabilitation staff in organizing and recording the kinds of activities, tasks and contacts necessary to establish and maintain a system of referral sources and a flow of cases, especially the cases of the severely handicapped. The guide contains a series of exercises which show the reader where improvement might be needed in his/her referral process. Topics discussed are the inventory, assessment, efficiency, priorities, goals, and time structuring. (SH)

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Understanding the Guidelines

for the

Rehabilitation Act of 1973

on

Expanding and Improving Services to the

Severely Handicapped

The Referral Process

A Training and Discussion Guide

1975

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Preface

One of the important aspects of expanding and improving services to the severely handicapped is to insure that the severely handicapped of a community know about the agency and that the staff of the vocational rehabilitation agency knows about the potential clients. In the state agency the responsibility for developing and maintaining an effective referral system is shared by the administrative and policy-making staff and by the staff who serve clients directly, such as rehabilitation counselors and first line supervisors. The responsibilities of the administrative staff in referral finding include arranging state-wide cooperative agreements between state agencies, and developing and monitoring statewide goals for the number of clients and types of disabilities to be served.

The responsibilities of the field staff are numerous and diversified. It takes time and energy to establish the proper number and types of referrals that an agency should receive, and to maintain this level.

These materials are designed to assist rehabilitation field staff in organizing and recording the kinds of activities, tasks, and contacts that are necessary to establish and maintain a system of referral sources and a flow of cases to the agency. The trainee should be able to inventory his current case finding contacts, to assess his effectiveness, and to decide how he would like to reorganize, concentrate, or increase some of his case-finding efforts and set some goals for improvement.

Not all trainees will use this material in the same way or for the same length of time. For some rehabilitation counselors, referral finding has always required much time and planning.

Thus, this unit will be a refresher course and it may offer a few new techniques. Other rehabilitation counselors have spent little time in case finding and public education. Their agencies seem to just "naturally" receive referrals that represent a broad range of disabilities and sufficient clients to meet agency goals. Now that the Rehabilitation Act of 1973 and the 1974 Amendments have emphasized that vocational rehabilitation caseloads must contain a large proportion of severely handicapped clients, counselors in these agencies may welcome this training as a way to assess what they have done in the past, what they need to do now, and how to develop a new strategy of case finding.

This training guide is an active learning unit. This means that the trainee must contribute and be actively involved in thinking, listing, and evaluating the activities, skills and goals that he thinks are necessary to establish and maintain an effective flow of referrals to vocational rehabilitation. This training is most effective if conducted with groups of five to ten persons who have direct responsibility for case finding. Since the unit is self-pacing, the leader can also be a participant. It is recommended that a group be formed consisting of all the field staff in one office or geographic area who might contact or develop the same referral sources.

This material can also be useful as an individual learning unit, if group work is not feasible. If you follow the study guide and do the exercises alone, try to discuss your final goals and schedule with someone, such as another counselor or your supervisor.

"Notes" to the Discussion Leader

This is a guide for a half-day to one-day training session. Training that follows the suggested format will be a series of

structured discussions. Each discussion will focus on a written exercise and each group will be responsible for an answer, list, or some other outcome for the discussion.

This format of structured group discussion is based on the belief that in-service training brings together counselors and supervisors who have much knowledge about rehabilitation, and many skills in referral finding. Through structured discussions, the knowledge, skills and experiences of each participant are shared with each other participant. Also, through group problem solving, new ideas are often generated.

Read the entire text before you conduct the discussion. If you are involved in referral finding activities, then actively participate in the goal-setting and assessment activities. If your primary responsibilities are for training and you are not actively involved in referral finding, it might be more appropriate for you to facilitate the discussion, but not actively participate in it.

The discussion leader's responsibility in this training is to keep the group working on their assigned tasks, to encourage all trainees to talk to each other.

Throughout the guide you will find "Notes" which are short sections containing specific instructions or ideas for discussion leaders and trainers.

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SECTION I

Why Is There A Need? — Introduction

Expanding and improving services to the severely handicapped is a phrase that we hear frequently now that the Rehabilitation Act of 1973 and the Amendments of 1974 are the legislation that support and influence vocational rehabilitation. The overall intent of the Act seems to be to insure that vocational rehabilitation, quickly and efficiently, serves first those severely handicapped clients with the most potential for rehabilitation. To serve these clients, they must be referred or find their way to the agency. This means that the staff of vocational rehabilitation agencies must accept the responsibility to evaluate the practices and attitudes that currently affect the referral process. For example, "who gets referred", "who in the community learns about the agency and its services", and "how other social service agencies feel about vocational rehabilitation" affect the referral process.

Consequently, if services to the severely handicapped are to be expanded and improved, the referral system of the agency must be expanded and improved. This task is complex because the referral process for vocational rehabilitation is diverse and multi-dimensional. It differs from state agency to state agency and, frequently, the tasks that are necessary for finding referrals and maintaining relationships with referral sources are even different from office to office within one agency. For instance, in rehabilitation there is disagreement about who should be responsible for case finding, and who should be responsible for community education and public relations activities. The assignment of these responsibilities varies. Some agencies encourage involvement of counselors in case finding, while

other agencies expect only office, district or regional supervisors to be responsible for case finding. Some agencies have no set policies about referral finding.

With all this divergence within the profession, there is no single or "right" way to expand or improve referrals to vocational rehabilitation. Thus, training such as this one, cannot provide a single set of rules or a formula for establishing an effective referral process, but can only indicate those areas that should be evaluated.

SECTION II

What Can We Do?

The referral process includes all the actions, efforts, skills, or techniques that the counselor uses to insure that potential clients know about vocational rehabilitation and that the agency knows about potential clients. This training is for field staff and it focuses on the specific actions and techniques that might be used to establish or maintain an effective pattern of referrals to the agency.

The goals for this training are:

1. To discuss general definitions, descriptions and components of the referral process in vocational rehabilitation.

2. To present generally applicable and acceptable methods and techniques of finding or maintaining referrals or referral sources.

3. To encourage participants to discuss knowledge, skills, or techniques about referral finding.

4. To provide basic information and structured exercises to enable trainees to identify problems in their referral finding practices.

5. To enable each trainee to set goals for improving his referral patterns, and to establish a program and schedule to achieve these goals.

SECTION III

Where Do We Start?— Definitions

We have already established that one way to expand and improve services to the severely handicapped is to expand and improve the referral process so that severely handicapped people can find their way to the rehabilitation agency. Let's begin by discussing what is meant by a referral. When asked this question, some counselors are quick to answer that *a referral* is the client who is currently in Status 00. Other rehabilitation workers suggest that a referral is any potential client with whom the agency has contact even if the case is not in Status 00; and some staff believe that a referral is any person who is known to the agency as a potential client.

In these materials, we define a referral as any potential client who is known to the agency. We define the referral process as the activities or tasks that are required to establish or maintain a flow of potential clients (referrals) into the vocational rehabilitation agency.

Opinions and definitions also differ about the referral process and who should be responsible for the tasks that are necessary to maintain an effective and adequate flow of referrals.

An effective *referral process* is even more difficult to define. What is an effective process in a Harlem DVR office may not be effective in a small rural West Virginia DVR office. Because each office, each region, and each state is unique, different combinations of the number of referrals and the types of disabilities referred are necessary.

The agency must establish goals concerning the number of clients it wants to serve, and the types and severity of disabilities on which it wishes to focus. The effective referral process is one which meets these established agency goals. Effectiveness will be discussed more comprehensively in the sections on assessment and goal setting.

These broad definitions for a referral and the referral process provide the framework for listing and describing specific activities and guidelines for building or maintaining an effective network of referral sources.

Referrals to the vocational rehabilitation agency occur because people in the community have some knowledge of the agency's activities. Most of the information known by the community comes from contact, formal or informal, professional or personal, with the counselor or office administrator. The kinds of contacts that the counselor has with the community generally are one of the following types:

1. Contact with the community in the role of the professional rehabilitation worker;
2. Contact with the community for the specific purpose of providing information;
3. Contact with the community through clients;
4. Contact with the community as a private citizen.

Exercise 3.1

Using the above four types of contact with the community as categories, list and discuss one or two instances when you had success in obtaining referrals through each of the four kinds of contact.

1. _____

2. _____

3. _____

4. _____

"Notes"

We suggest only about 10 minutes for this activity. The goals for this activity are to encourage trainees to begin to think about their abilities in referral finding, and to become comfortable with the open ended discussion format and with the other members of their discussion group.

Discussion

This exercise is designed to stimulate your thinking about the different types of contacts that you have with the community and the many different ways you can (and probably already do) generate referrals.

Most counselors have specific activites they carry out primarily to find referrals. These activities usually involve professional contacts rather than social or personal contacts. Visiting with doctors or staff of social service agencies are two such activities.

Public education is another function that provides an opportunity for finding referrals. Speaking to local groups such as school, church, or civic organizations not only informs community residents of your agency's activities, but also establishes many community contacts.

Referral of potential clients by present clients is something that most rehabilitation counselors have experienced at one time or another . People with similar disabilities often discuss their difficulties and, in the process, share information about obtaining assistance. Many counselors have several members of the same family or a community as clients because one client had contact with the agency and told others about the services available.

Contact with the community as a private citizen may be a spontaneous and unplanned referral finding activity but it can be effective. It is not uncommon for a friendly conversation to reveal information about a potential client. For example, one counselor never missed his daughter's PTA meetings when she was in junior and senior high school. While the daughter received points for the attendance of her father, the father occasionally found a referral while chatting with other parents about the 'normal' and 'not so normal' problems of adolescents.

SECTION IV

An Inventory

So far we have established that the typical counselor has contact with the community in a number of different ways. In each contact with the community, he should be aware that the contact can lead to referrals.

Most counselors agree that although all types of contacts can be useful in maintaining an effective referral system, the preplanned contacts with the community as a representative of the rehabilitation agency are the most effective. These contacts are usually with a particular resource agency or person in the community. Becoming familiar with the various agencies and individuals in the community and making regular contact with them is required of the agency representative who wants to insure that all potential clients know about or are known to the agency.

An inventory of the community referral sources has proven beneficial to counselors. This is most helpful if it can be done with all the people who serve a certain geographic area, but it can also be useful if you work alone.

Exercise 4.1

Take some time now to list the referral sources in your community. We have provided some broad categories of referral sources to help you organize your inventory. First, list the agency or establishment and the individuals that you contact now; then list the potential referral agencies and individuals that you may want to use in the future.

"Notes"

We suggest that you spend at least an hour on this inventory. Do not use the columns marked "Frequency" or "Clients" at this time. Remind trainees to list the referral sources that they presently use and the potential sources of referral.

CATEGORIES OF REFERRAL SOURCES

Agency	Individual	Frequency	Clients
Public Social Services Agencies			
Private Social Service Agencies			

Agency	Individual	Frequency	Clients

Physicians (Private or Group Practice)

Rehabilitation Facilities

Agency	Individual	Frequency	Clients
Medical Clinics			
Associations (Special Interest Groups)			

Agency	Individual	Frequency	Clients
Government or Political Organizations			
Law Enforcement Agencies			

Agency	Individual	Frequency	Clients
Clients and Clients' Families			
Hospitals (and Physical Medicine Units)			

"Notes"

Appendix B lists those disabilities classified as severe and gives some of the organizations that work with these clients. Check these for potential referral sources.

Memory joggers – these are some of the important as well as less common referral sources that other rehabilitation counselors have provided:

Sheltered Workshops
Social Security (SSI and SSDI)
State Institutions and Hospitals
Physical Medicine and Rehabilitation Units of Hospitals
Convalescent and Nursing Homes
Work Activity and Day Care Centers
Yellow Pages
Community Resources Directories
Council of Social Agencies
Telephone Referral Systems
Crisis Counseling Centers
Hotlines and Consumer Advocacy Programs
Programs that serve other disabilities
Public Schools Systems, especially homebound and social service units
The public, private, corporate, and volunteer sectors of the community.

Discussion

This inventory allows agency representatives in a geographic area to become familiar with the agencies and individuals that might be potential sources of referrals to the agency. Often the

length of this inventory alone suggests how difficult the task of maintaining contact can be. In most areas it is unreasonable to assume that the counselor has time to keep regular contact with all of the resources, or that regular contact is necessary.

SECTION V

An Assessment

Most counselors and supervisors find that a change or an improvement in the referral network requires a reorganization of effort, rather than an increase in the time spent contacting resources. To determine if a reorganization of time or effort might establish or maintain a more effective network of referrals, it is necessary to review current activities and the results of these activities.

Exercise 5.1

This exercise requires you to return to the inventory sheets that were used in Exercise 4.1.

a. In the column marked "Frequency", estimate the number of contacts you have had with each referral source. The following code might make it easier to respond:

A = Weekly or more frequently

B = 2 to 3 times in a month

C = Once a month

D = 6 times in a year

E = 3 times in a year

F = Yearly or less often

If you are working in a group, you can use initials to indicate who is making the contacts.

b. Another task that will help you decide if your efforts are effective is to estimate the number of clients referred from each source in a year. You may make estimates from memory, or you may check your Master List for the last year it is available. Enter the estimate in the column headed "Clients".

"Notes"

These estimates are difficult to make and some trainees may be uncomfortable with this exercise. It is helpful to discuss that an assessment of the effectiveness of present activities must precede a reorganization of effort. This will guard against eliminating useful contacts or spending too much time in referral finding that is not likely to lead to attaining agency goals.

SECTION VI

Efficiency

The inventory, the estimate of the frequency of contact with each referral source, and the estimate of the number of clients referred by each referral source, provide you with a summary of your present referral network and the number of clients being obtained through this network. Your next task is to decide if you are obtaining enough referrals to merit the time you spend making contacts, and if the referrals that you obtain are the type and severity of disabilities that you want to be serving.

Efficiency is a concept that has more meaning when it is discussed in relation to a specific situation. For instance, to evaluate the efficiency of a referral system, three components of the referral process should be discussed: (1) the number of people who are referred; (2) the type and severity of the disabilities of the people who are referred; and (3) the amount of time and effort expended to secure the referrals. In the past, efficiency in the referral finding process in rehabilitation usually meant that the counselor had enough referrals to maintain an adequate caseload size, and that the caseload size was maintained with a minimum of time and effort.

Now that state agencies are setting goals to serve the most severely handicapped clients first, the efficiency of referral finding activities conducted by the field staff will need to be evaluated differently. Referral finding activities must now be directed toward generating the referral of certain types of clients as well as generating a sufficient number of clients.

In this section, we will discuss efficiency as it relates to meeting the goals of the agency, particularly those goals designed to meet the requirements of the rehabilitation legislation to expand and improve services to the severely handicapped.

To plan for the future, it is often necessary to describe the present. Many counselors are surprised to find that when they look carefully at their present caseload, they are very close to where they want to be in serving severely handicapped people.

Exercise 6.1

The following questions are designed to help you summarize your present caseload.

"Notes"

To complete these exercises, the trainee needs to have his client data or master list with him during the training. He or she will have to know some of the statistics about his or her caseload.

Current Statistics

a. How many referrals did you obtain in each of the last 12 months?

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

G. _____ H. _____

I. _____ J. _____

K. _____ L. _____

Total _____

b. How many of these were severely disabled? _____

c. How many of the severely disabled were accepted for extended evaluation? _____ for services? _____

d. What percentage of the last year's referrals are severely disabled or apparently severely disabled?

$$\frac{\text{Number of Severely Disabled}}{\text{Total Referrals}} = \text{_____}$$

e. What percentage of your entire caseload at this time is severely disabled? _____

f. Of the persons with severe disabilities referred, what are the disabilities that are represented? (See Appendix A for a list of the severe disabilities, if you need some assistance.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

g. Are there any severe disability groups that are not represented in your caseload? If so, please list these.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

"Notes"

The exercise in this section is to be completed individually. It gives the trainees a change of pace from the group discussion format that has been used for previous sections.

If time is limited, it is possible to have these exercises completed by the trainee before he attends the training session.

SECTION VII

Priorities

Because of budgetary and other constraints, rehabilitation agencies are not able to serve all the people that need services. (According to the 1970 census, 7 million people are eligible for vocational rehabilitation.) It is unrealistic to attempt to contact each of the different individuals that might be eligible for vocational rehabilitation. Similarly, it is also unrealistic to expect that every counselor's caseload will contain every disability type. For counselors to spend time efficiently, it is helpful to designate several "target groups" and let counselors concentrate on referral finding within these target populations. In rehabilitation, the "target populations" are various disability groups.

Exercise 7.1

List three disability groups that are not represented or are not represented adequately in your caseload. Assign a priority to each so that you will use your referral finding time first on the group with the highest priority.

Disability Groups	Priority
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

"Notes"

Some agencies may have statewide assignments of priority for certain disability groups, and you should include these.

Along with target groups, it is helpful to determine the number of referrals needed to maintain an optimal caseload. The following two questions deal with projections about this component of the referral process:

In order to maintain the optimal caseload size, how many referrals should you add to your caseload per month? _____

Of these, how many should be severely disabled? _____

SECTION VIII

Goals

You are now ready to summarize the information that you have compiled on the preceding pages, and to write your goals.

Types of Referrals

I want to concentrate my referral finding efforts on clients with the following disabilities:

1. _____

2. _____

3. _____

(List three at the most. Goals should be realistic and your time is limited.)

Number of Referrals

a. During the next three months, this is the number of referrals that I will add to my caseload _____

b. Complete the most appropriate of the following statements:

1. This represents an increase of _____ referrals per month from the previous three months.
(how many)

2. The number of referrals will remain the same but I will work for more referrals of the severely disabled, especially _____
(type of disability)

3. The overall number of referrals will be less, but I will work for an increase in the number of severely disabled, especially _____.
(type of disability)

Summary of Projections

Present caseload size (total in all active statuses) _____

Number of severely disabled presently _____

Number of referrals projected for the next 3 months _____

Number of severely disabled referrals projected for the next 3 months _____

"Notes"

Some people who work in vocational rehabilitation feel pressured when asked to set goals that include estimates of the number of clients to be served. They feel that rehabilitation is a service that responds to the client's needs as they arise and that services are provided on the basis of the client's needs. Establishing goals, including projections of the number of clients to be served, limits or controls the services offered and the clients eligible to receive the services. The use of the number of cases closed as a major criterion for evaluating the success of rehabilitation programs has led to abuses in the system. An overemphasis on numbers and the belief that the needs of potential clients can not always be accurately predicted, have made many people in rehabilitation wary of goal setting.

These objections and reservations may surface in this training or as you are working on these exercises. The leader needs to be prepared to discuss the necessity and proper uses of goals.

The goals that the trainees have established for referrals are only guidelines. Since everyone cannot be served, goals are helpful to the counselor and to staff of a territory or district in assigning priority to the needs of some of the clients in the area, and in determining how time and resources may be best used.

Discussion

A goal can be a tool. For instance, the counselor who is mandated by his agency to serve more severely handicapped clients is faced with such questions as "What do I do now?" or "Since I can't do everything, what should I do first?" Specifically defined goals can aid in structuring time and activities in such a way that the counselor knows what to do first and he can systematically and efficiently attempt to meet the mandate.

Here are some suggestions for the counselor for making useful tools of the goals that have been developed.

1. When writing or revising goals, keep them realistic. Progress is made with small, steady steps. Most rehabilitation workers must accomplish their goals without much increase in amount of time spent for referral finding.

2. Goals are guidelines for allocating time and resources so that those who require services the most get those services. If your own judgment of a case puts you in conflict with a goal, perhaps the goal wasn't an effective one to begin with, or maybe it is time to make an exception.

3. Be open'minded about the value of certain goals. If the community practices or your own, are at odds with the outcome you desire, then you may have an ineffective goal. If it is an agency goal, then maybe the administration needs your input about the difficulties that are inherent in attaining this goal.

SECTION IX

Time Structuring

You now have goals setting the number of referrals you will be seeking and the types of disabilities you would like to be adding to your caseload. You have determined what you would like to add to or change in your caseload. Since referral finding is only one of many duties that you perform in a day or a month, you will need to allocate time to do the referral finding activities.

You may want to spend the same amount of time that you now spend or you may want to allocate additional time for referral finding activities.

Exercise 9.1

a. To begin to structure your time, estimate how much time you presently spend in a week primarily doing referral finding, including specific client outreach_____. (Be sure to include the time you spend in contact with people outside the agency when referral finding might be only part of the reason for the contact).

b. How many hours per week will you need to spend to meet the goals for referrals that you have set?_____

c. Projection

Use this schedule to be more specific in allocating your time for referral finding activities.

	Monday	Tuesday	Wednesday	Thursday	Friday
Week One					
Week Two					
Week Three					
Week Four					

SECTION X

Some Ideas About the Process

In this training we have dealt with issues such as who the counselor should contact to establish sources of referral, assessing the effectiveness of referral finding activities, and goal setting for types of disabilities, numbers of clients, and counselor time to be spent in referral finding.

This section discusses what counselors can do to make their time and contacts most useful.

There is no standard, "best", or "most effective" method for increasing the number of referrals or for influencing the kind of referrals that the vocational rehabilitation agency receives. The ways referrals are obtained is a function of two factors: the counselor and the community. The counselor brings to the process of referral finding his personality; his past experiences; his relationship to the community, its leaders, and other social service agencies; and his orientation to and philosophy of rehabilitation, as it relates specifically to the referral finding function.

The community affects the referral process by its size, level of income, types of industry, culture, and the attitudes prevalent in the community. The unique combination of the individual counselor with the community makes it impossible to formulate a schedule of activities. However, many systems and ideas for obtaining referrals have been tried in various rehabilitation agencies, and a review of these ideas might offer some suggestions for you to incorporate into your referral finding activities.

Expanding or improving sources of referral to include referrals of more severely handicapped people is a slow and steady process to be incorporated with other aspects of expanding and improving services to the severely handicapped.

Exercise 10.1

Present to your discussion group one or two of the techniques that you have found to be useful in making contact with a potential referral source in maintaining a working relationship with a referral source, or in any other aspect of the referral finding process.

"Notes"

Each person in the group should present one suggestion. Try to make each suggestion different or in some way unique from the others. After each member has presented, the discussion can be opened to any other suggestions members want to make, or to discussing the advantages or disadvantages of the suggestions. This exercise requires that a group member or the leader act as secretary to record each idea or suggestion as it is presented. The following format for recording may be useful.

Pages 33-40, a duplication of page 41, were removed. They are not included in the pagination.

Suggestion:

Advantages:

Disadvantages:

The following pages contain some of the ideas and suggestions that we have accumulated. Some of these probably will be similar to those discussed in your group and some may not have been mentioned.

Read through these referral finding ideas. From these ideas and from those presented in your discussion group, select one or two new behaviors or new variations to try during the time you have set aside in your schedule for referral finding. You can make a notation on the schedule developed in Exercise 9.1 to indicate when you will try out this activity.

Efficient Use of Contact

Expanding and improving the referral process does not necessarily mean spending more time in referral finding, outreach, or community education. For most counselors there just isn't any more time. More time is usually not needed, only better organization of the time and activities already devoted to the referral process. Efficient use of a single contact can result in spending less time for effective referral finding. One method is to combine contacts about other matters with referral finding. For instance, the contacts needed for a continuous referral finding and community education network often can be made while

- job finding,
- giving feedback about clients that have been referred in the past,
- following up on employed clients, or
- meeting with personnel of other agencies.

New Referral Sources

It is wise to encourage new referral sources to refer any potential client to vocational rehabilitation. Occasionally, a new referral source is inclined to send only those clients they think are assured or certain of eligibility. The counselor should encourage persons who make referrals to be more liberal in their referral practices. It is important that the VR agency does not give the impression it is only interested in a referral that is sure to be eligible, or that it resents being bothered with referrals of questionable eligibility.

As a general rule, when working with a new referral source most rehabilitation counselors prefer to see all referrals. Otherwise, there is the risk of losing a potential client or a particular type of client that might be eligible for vocational rehabilitation services.

Sometimes an agency or person in the community uses the referral process to refer persons who are obviously not eligible for services. If this occurs repeatedly, the counselor should talk with the person referring the cases to explain in detail the goals of vocational rehabilitation services, and the eligibility criteria.

Feedback

When a person makes a referral to the agency, it is most important to let that person know what happens to the referral. A person who cares enough to make a referral appreciates feedback from the counselor. That feedback should be immediate and meaningful. To meet the immediate need, the counselor

could send a letter of appreciation or telephone the person. Since, in the early stage of the referral process, it is usually not possible to tell the referral source if the client is eligible, some counselors have used this contact to discuss the evaluation process and eligibility criteria in general. In this way, the referral source learns more about the agency, and he knows that his referral has been received and that some action will be taken.

Always remember that anybody who makes a referral deserves some kind of feedback. It can be as formal as a letter or as informal as a phone call. The feedback to the referral source should refer specifically to the particular case. For example, a sentence such as "We have taken that matter under advisement" is not as useful as "I wanted to let you know that I saw Mary Liston. She is interested in more information about VR and we are going to get together next week."

The type and amount of information you share also will depend on the person who made the referral. For instance, if the referral source is a social worker with another agency, and the client has given you a release of information for this person, then you can be quite specific about the data that you share. On the other hand, if the referral source is an interested neighbor of the client's, only general information is appropriate.

Besides being immediate, feedback should also be meaningful. A brief contact with the referral source at significant times in the client's rehabilitation process can provide meaningful feedback. For example, if a physician referred a quadriplegic client to vocational rehabilitation, he might appreciate a phone call telling him that the client has entered a training program at

a comprehensive rehabilitation center, and a call a year later saying that the client had graduated. This meaninful information is an effective supplement to the immediate feedback that should accompany every referral.

Giving feedback to the referral source supports the importance and value of making a referral. Feedback will increase the likelihood that that person will refer another person to vocational rehabilitation.

The client's rights to confidentiality and privacy must be protected, and any feedback to a referral source should be carefully tailored to maintain these rights.

Interagency Network

One of the most helpful ways of obtaining referrals to vocational rehabilitation is to be a part of a community-wide referral network. This involves working closely with all other agencies in the community. So you are in a position not only to receive referrals, but also to make referrals to other agencies when you see people who might need their services. By knowing what services other agencies offer, you can see that the client receives all the services he needs and, at the same time, you can establish a relationship of joint assistance for the clients in your territory or community.

An extension of this concept is to be involved in a Council of Social Agencies, or to become familiar with similar organizations that have members from all the social service or community service agencies.

A close inter-agency working relationship is very efficient and helpful to both clients and agencies. It requires caution to insure that a representative of one agency does not make promises or interpretations of policy, services, or eligibility for other agencies. It is also risky for the rehabilitation counselor to make firm statements about services that other agencies can provide, and for a counselor to allow another person to speak for vocational rehabilitation.

Outreach

Outreach is generally defined as the process of seeking out or extending assistance to a person or group. In vocational rehabilitation, it is the efforts of a counselor to make contact with a specific person who is a potential client of rehabilitation.

Counselors who serve SSI and SSDI recipients spend a great deal of time in specific client outreach.

Outreach activities can be:

1. a letter that introduces the agency;
2. a letter from the counselor that requests an appointment;
3. a phone call;
4. a visit to the person's home;
5. an explanation to the family about the agency and its services.

Outreach is not always easy. To verify this, one counselor submitted the following communication from a social worker with the Department of Welfare who referred a client:

Directions to Client's Home

Go out of the city north on Route 18 to secondary Route 345 (about 12 miles). Turn west on Route 345 and go 6 miles. There you'll find a fork in the road; the left side is paved and the right side is not paved. Proceed on the unpaved (right) fork until you come to a one lane bridge. Immediately after you cross the one land bridge, turn left and go ½ mile. Here the road ends. Park your car and walk across the first field and across the second field until you come to the second barbed wire fence. Don't cross this fence until you have called to someone in the house, because they have dogs. (The rumor is that the dogs bite strangers). The dogs won't harm you if someone in the house says it is O.K. for you to cross the fence.

SECTION XI

Summary

This training was developed as part of a response to the legislative mandates to vocational rehabilitation to serve the most severely handicapped clients first.

It is designed to assist you to expand your thinking about the referral process and about the plans and goals that rehabilitation counselors and supervisors must make to insure that there will be a sufficient number of severely disabled referrals to the vocational rehabilitation agency. Another purpose of this training is to enable you to look objectively at the referral finding component of your casework and to establish some goals concerning:

- the number of referrals;
- the kinds of disabilities of the people who are referred;
- the time necessary to maintain a referral system; and
- the types of referral finding activities that can be useful to a rehabilitation counselor.

These goals are guidelines to assist you in allocating your time and planning your referral finding activities. These goals should be reevaluated at the end of three months to determine if you have obtained the results that you wanted to obtain.

If you have not met your goals, return to Sections 7, 8 and 9 of this manual. Reassess the referral needs of your territory and the time and activities that you should use to meet these needs.

APPENDIX A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D. C. 20201

PROGRAM INSTRUCTION
RSA-PI-74-16
December 20, 1973

TO: STATE REHABILITATION AGENCIES (General)
STATE REHABILITATION AGENCIES (Blind)

SUBJECT: The Severely Disabled: Their Priority for Service, Definition, Identification and Reporting.

CONTENT: 1. Priority Emphasis

The Rehabilitation Act of 1973 (P.L. 93-112), enacted September 26, 1973, among other purposes, provides vocational rehabilitation services to handicapped individuals, "serving first those with the most severe handicaps". This emphasis on the severely handicapped is evident throughout the Act and is a clear mandate that the State-Federal vocational rehabilitation program, while still employment oriented, will concentrate its efforts on those with the most severe disabilities. At the same time, Congress indicated that the program is not to be an exclusively "severely handicapped" program and that no handicapped person is to be turned away by reason of the type of his disability.

2. Definition

The Act speaks of severe handicap but defines it in terms of disability and categories of conditions and diseases. These conditions are evidenced by medically discernible impairments with specific limitations. A severely handicapped individual, then, is a person who has a severe disability, which is defined on an interim basis, as:

> that physical or mental impairment which seriously limits the functional capacities (mobility, communication, self-care, self-direction, work tolerance, work skills) of a handicapped individual to the extent that the person is unable, to a substantial degree, to cope with the physical or mental demands of gainful employment and whose rehabilitation normally requires multiple services (restorative, compensatory, training, selective placement) over an extended period of time.

3. Identification

With an order of priority for service established, it is necessary to identify the severely disabled early in the rehabilitation process. In order for States and Central Office to effect the orientation of the program toward emphasis on the severely disabled and monitor progress, we must have a procedure as uniform, objective and operationally simple as possible for delineating this priority population without excessively disrupting the present reporting system. To meet these objectives, for Fiscal Year 1974 (subject to later changes based on experience), the following four-group operational application of the definition will be used to determine those clients or applicants to be considered severely disabled:

A. A list of disability codes (Attachment A), which experience and statistical analysis indicate, meet the definition of severity, comprising:

(1) Disabilities for which all clients so coded will be automatically included (e.g., See Attachment A 100-119 Blindness both eyes)

(2) Disabilities with qualifying conditions - clients so coded will be automatically included only if the qualifying conditions apply (e.g., See Attachment A 340 Impairment of one or both upper limbs due to cerebral palsy - if both limbs are impaired and assistance by another person or devices is needed for activities of daily living).

B. All Social Security Disability Insurance (SSDI) beneficiaries will be included automatically.

C. All blind and disabled Supplemental Security Income (SSI) recipients will be included automatically.

Both Groups B and C will have undergone rigorous, documented medical assessment against the criterion of total disability for any substantial gainful activity.

D. Other individual cases with documented evidence of loss and limitation comparable to the disabilities listed on Attachment A and meeting the criteria of Functional Limitation Factors (Attachment B).

4. Reporting

As soon as practicable after January 1, 1974 and no later than March 29, 1974, State vocational rehabilitation agencies will complete a review of all active cases (Status 10 and above and any earlier status for which adequate diagnostic data is available) in their caseloads and determine in accordance with the above instructions which clients or applicants are severely disabled. To identify them the Form RSA-300 will be marked with an X above the 400 code in Item A of Part 3 of the Form. The sum of codes in this item will then be increased by 400. The uppermost box of the set is to be labeled SD (Severely Disabled). Agencies submitting punched cards or magnetic tapes should assure that the new sum is reflected in columns 65-67 of card number 1 and columns 14-16 of card number 2. Thereafter, new cases should be identified as severely disabled and the RSA-300 marked as early after intake as possible after receipt of adequate diagnostic information.

A similar 100% review determination and identification procedure will be accomplished by States for all cases closed rehabilitated between July 1, 1973 and December 31, 1973. It is recognized that in many instances the RSA-300 data records will have been already reported to Central Office and that the SD designation will not, of course, appear on these records. Agencies will not be required to resubmit these records. Instead, a separate count of the number of severely disabled rehabilitations will be derived and the number reported by phone to the Regional Office (RS) as soon as possible after January 1, 1974. Each individual case should be clearly identified for possible follow-up as

having been determined and counted as severely disabled. The purpose of this review is to establish a statistical base of severely disabled rehabilitations for an entire fiscal year (1974) for analysis and future comparison.

In conducting both reviews, all established Aid to the Blind (AB) and Aid to the Permanently and Totally Disabled (APTD) cases, both active and closed rehabilitated, will be identified as severely disabled inasmuch as they will be (or would have been) "Grandfathered" into the SSI program on January 1, 1974.

5. Reports

A cumulative report for the first six months of Fiscal Year 1974 will be furnished by phone to the Regional Offices (RS) as soon as possible after January 1, 1974 of the number of severely disabled cases closed rehabilitated. Thereafter, quarterly cumulative reports will be submitted, of the number rehabilitated. The quarterly reports will be either added to the current RSA-100 form or requested in a separate format.

INQUIRIES TO: SRS Regional Commissioners

James R. Burress

Acting Commissioner
Rehabilitation Services Administration

Attachments

IDENTIFICATION OF THE SEVERELY DISABLED

Record as severely disabled cases in any of the following four categories.

1. Clients with major disabling conditions listed below, as qualified in some instances.

RSA Disability Code	
100-119	Blindness, both eyes
120-129	Blindness one eye, other eye defective
140-149	Other visual impairments if, with correction, unable to obtain driver's license for visual reasons
200-219	Deafness, able or unable to talk
220-229	Other hearing impairments if loss exceeds 70 decibels in better ear in conversational range with correction
300-319	Orthopedic impairment involving three or more limbs
320-339	Orthopedic impairment involving one upper and one lower limb (including side)
340,341,343, 350,352,354, 357,359	Orthopedic impairment involving one or both upper limbs (including hands, fingers, and thumbs)- if both, and assistance of another person or devices is needed for activities of daily living
360,361,363, 370,372,374, 377,379	Orthopedic impairment involving one or both lower limbs (including feet and toes) - if locomotion is impaired to a degree that bilateral upper limb assistance devices are required, or individual is unable to utilize public busses or trains

355,375,395	Muscular dystrophy
356,376,396	Multiple sclerosis
358,378,398	Accidents and injuries involving the spinal cord
400-409	Loss of at least one upper and one lower extremity (including hands, thumbs, and feet)
410-419	Loss of both major upper extremities (including hands or thumbs)
430-439	Loss of one or both major lower extremities
	if bilateral at the ankle or above, or if one at mid-thigh that requires bilateral upper limb assistance devices, or individual is unable to utilize public busses or trains
500	Psychotic disorders
	if now requiring institutional care in a mental hospital or psychiatric ward of a general hospital; or has history of being institutionalized for treatment for three months or more, or on multiple occasions; or meets the description for moderate or severe on the next page.
Mild:	Minor distortions of thinking with little or no disturbance in activities of daily living. With provision of rehabilitation services, can maintain independent living in the community and engage in competitive employment. Able to accept direction, maintain adequate interpersonal relations and concentrate sufficiently to perform job requirements. Only under occasional conditions of particular internal, social or economic stress, may require follow-up supervision, guidance or support. Includes one-time, short-term institutionalized dischargees doing well on medication.

Moderate: Definite disturbances of thinking with definite but mild disturbances in behavior. Includes hospital dischargees who require daily medication to avoid rehospitalization. With provision of rehabilitation services, capable of maintaining themselves in the community and of engaging in low-stress competitive employment, but at least initially requiring continuing supervision, guidance, motivation and support. Misunderstanding of instructions, activity, self-isolation, or over-reaction in gesture, speech or emotion may be displayed during the VR process and may cause concern to people in the work milieu.

Severe: (a) Severe disturbances of thinking and behavior that entail potential harm to self or others; (b) or, in the extreme, severe disturbances of all components of daily living, requiring constant supervision and care. Persons in (a) with the provision of rehabilitation services may be capable of maintaining themselves in the community and to engage in limited or sporadic productive activity only under continuing supervision in sheltered or protective environment, including halfway houses. They are unable to communicate readily and have difficulty differentiating between their fantasies and reality. Their behavior is disruptive and often menacing to others, marked by shouting, vulgarity, carelessness of dress and excretory functions. These symptoms and possible suicidal attempts necessitate continuing observation, professional intervention and medication, especially during early stages of the rehabilitation process.

510 Psychoneurotic disorders

if now requiring institutional care in a mental hospital or psychiatric ward of a general hospital; or has history of being institutionalized for treatment for three months or more, or on multiple occasions; or meets the description of moderate or severe on the next page.

Mild:	Stress reactions to daily living without substantial loss of personal or social efficiency. With the provision of rehabilitation services, can maintain independent living in the community and engage in competitive employment. Can accept direction, maintain adequate interpersonal relations and concentrate sufficiently to perform job requirements. Only under occasional conditions of particular internal, social or economic stress will require supervision, guidance and support after placement.
Moderate:	Stress reactions which modify patterns of daily living. Can maintain themselves in the community and perform adequately in low-stress competitive employment with the provision of rehabilitation services. May require medication and continuing supervision, motivation and support at least during early post-placement. Their fears, indecision, loss of interest or occasional odd behavior will be evident during the rehabilitation process, and may moderately interfere with job performance and other worker's activities in employment when stressful situations arise.
Severe:	Stress reactions to daily living that result in continuing regression and tissue-organ pathology. Capable of productive work but only under sheltered, non-competitive conditions in a highly structured or protective environment, at least initially. May require continuing medication. Bizarre and disruptive behavior, loss of interest in activities of daily living, problems with memory and concentration will be evident in the counseling process. These symptoms and the client's interference with other workers necessitate continuing supervision, guidance, motivation and support by professional staff in the work situation. Conversion reactions, poor eating and cleanliness habits may create considerable health problems.
532,534	Mental retardation - moderate and severe
600	Colostomies resulting from malignant neoplasms
601	Laryngectomies resulting from malignant neoplasms

602	Leukemia and aleukemia
616	Cystic fibrosis
620	Hemophilia
621	Sickle cell anemia
630	Epilepsy - if not seizure-free for two years
640-644	Heart conditions - if classified 2C or worse in the New York Heart Association Classification as adopted by the American Heart Association.
651-654,659	Respiratory system conditions - if maximum breath capacity is less than 55 percent of predicted or shortness of breath on climbing one flight of stairs or walking 100 yards on the level.
664	Colostomies (from other than malignant neoplasms)
671	End-stage renal failure
680	Cleft palate and harelip with speech imperfections
684	Laryngectomies (from other than malignant neoplasms)
685	Aphasia resulting from intracranial hemorrhage, embolism, or thrombosis (stroke)

2. Clients who, at any time in the vocational rehabilitation process, had been Social Security Disability Insurance (SSDI) beneficiaries.

3. Clients who, at any time in the vocational rehabilitation process, had been recipients of Supplemental Security Income (SSI) payments by reason of blindness or disability.

4. Other individual cases with documented evidence of loss and limitation meeting the criteria of Functional Limitation Factors.

In this grouping are those conditions, whether a single disability or a combination of disabilities, which when presented in terms of clinical description and functional limitations, the State agency (counselor/medical consultant) can determine:

A. There exists substantial loss of functional capacity and restriction of activity attributable to medical factors, such that the client:

1. Is unable to make use of public bus or train, or

2. Is unable to perform sustained work activity for six hours or more, or

3. Has disfigurement or deformity so pronounced as to cause social rejection, or

4. Speech is unintelligible to non-family members, or

5. Is unable to climb one flight of stairs or walk 100 yards on the level without pause, or

6. Has loss of manual dexterity or coordination sufficient that he is unable to button buttons, wind a watch or write intelligibly; and

B. The client will normally require multiple vocational rehabilitation services over an extended period of time.

APPENDIX B

100-119 Blindness both eyes -

120-129 Blindness one eye, other eye defective -

*140-149 Other visual impairments -

if, with correction, unable to obtain driver's license for visual reasons

American Association of Workers for the Blind, Inc.
1511 K Street, N.W.
Washington, D. C.
202/347-1559

American Optometric Association
44 E. 23rd Street
New York, New York 10010
212/477-9170

National Federation of the Blind
1346 Connecticut Avenue
Washington, D. C. 20036
202/785-2974

International Eye Foundation
5255 Loughborough Road, N.W.
Washington, D. C. 20016
202/966-3816

200-219 Deafness able or unable to talk -

*220-229 Other hearing impairments -

if loss exceeds 70 decibels in better ear in conversational range with correction

National Association of Hearing and Speech Agencies
814 Thayer Avenue
Silver Spring, Maryland 20910
301/588-5242

National Association of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910
301/587-1788

300-339 Orthopedic impairment involving 3 or more limbs/or involving one upper and one lower limb -

American Physical Therapy Association
1156 15th Street, N.W.
Suite 500
Washington, D. C. 20005
202/466-2070

355, 375, 395 Muscular dystrophy -

Muscular Dystrophy Association of America
810 7th Avenue
27th Floor
New York, New York 10019
212/586-0808

356, 376, 396 Multiple sclerosis -

Multiple Sclerosis Society
257 Park Avenue, S.
New York, New York 10010
212/674-4100

358, 378, 398 Accidents and injuries involving the spinal cord -

*340, 341, 343, 350, 352, 354, 357, 359 Impairment of one or both upper limbs -

if both, and assistance of another person or devices is needed for activities of daily living

*360, 361, 363, 370, 372, 374, 377 Impairment of one or both lower limbs -

if locomotion is impaired to a degree that bilateral upper limb assistance devices are required, or individual is unable to utilize public buses or trains

Paralyzed Veterans of America, Inc.
7315 Wisconsin Avenue
Suite 301
Washington, D. C. 20014
301/652-3464 (Maryland exchange)

400-409 Loss of at least one upper and one lower extremity -

National Association of the Physically Handicapped
6473 Grandville
Detroit, Michigan 48228
313/271-0160

410-419 Loss of both major upper extremities -

*430-439 Loss of one or both major lower extremities -

if bilateral at the ankle or above, of if one at mid-thigh that requires bilateral upper limb assistance devices, or individual is unable to utilize public buses or trains

National Amputation Foundation
12-45 150th Street
Whitestone, New York 11357
212/445-2680

*500 Psychotic disorders -

if now requiring institutional care in a mental hospital or psychiatric ward of a general hospital; or has history of being institutionalized for treatment for three months or more, or on multiple occasions; or meets the description on Page 4 for moderate or severe.

American Psychiatric Association
1700 18th Street, N.W.
Washington, D. C. 20009
202/232-7878

*510 Psychoneurotic disorders -

if now requiring institutional care in a mental hospital or psychiatric ward of a general hospital; or has history of being institutionalized for treatment for three months or more, or on multiple occasions; or meets the description on Page 5 for moderate or severe.

American College of Neurophychiatrists
27 E. 62nd Street
New York, New York 10021
212/980-3318

532-534 Mental retardation - moderate and severe -

American Association on Mental Deficiency
5201 Connecticut Avenue, N.W.
Washington, D. C.
202/244-8143

Educational Guidance Center for the Mentally Retarded
1235 Park Avenue
New York, New York 10036
212/876-1609

600- Colostomies resulting from malignant neoplasms -

International Academy of Proctology
147-41 Sanford Avenue
Flushing, New York 11355
212/359-3465

Colostomies (Continued)

American Society of Colon and Rectal Surgeons
320 W. Lafayette
Detroit, Michigan 48226
313/961-7880

601 - Laryngectomies resulting from malignant neoplasms -

International Association of Laryngectomees
c/o American Cancer Society
219 E. 42nd Street
New York, New York 10017
212/867-3700

602 - Leukemia and Aleukemia -

Leukemia Society of America
211 E. 43rd Street
New York, New York 10017
212/573-8484

*615 - Other endocrine system disorders -

if cystic fibrosis

Cystic Fibrosis Foundation
3379 Peachtree Road, N.E.
Atlanta, Georgia 30326
404/262-1100

620 - Hemophilia -

National He.nophilia Foundation
25 W. 39th Street
New York, New York 10018
212/279-0397

*629 Anemia and other diseases of the blood and blood forming organs -

if symptomatic sickle cell anemia

Cooley's Anemia Blood and Research Foundation for Children
3366 Hillside Avenue
New Hyde Park, New York 11040
516/747-2155

National Hemophilia Foundation
25 W. 39th Street
New York, New York 10018
212/279-0397

National Sickle Cell Disease Research Foundation
New York Branch Office
520 Fifth Avenue
New York, New York 10036
212/276-4339

630 Epilepsy -

if not seizure-free for two years

Epilepsy Foundation of America
1828 L Street, N.W., Suite 406
Washington, D. C. 20036
202/293-2930

*640, 641, 642, 643, 644 — Cardiac and circulatory conditions -

if classified 2C** or worse

American Heart Association, Inc.
44 E. 23rd Street
New York, New York 10010
212/477-9170

Heart Disease Research Foundation
963 Essex Street
New York, New York 11208
212/649-9003

*651, 652, 653, 654, 659 — Respiratory diseases -

if maximum breath capacity is less than 55 percent of predicted or shortness of breath on climbing one flight of stairs or walking 100 yards on the level

American Association for Respiratory Therapy
7411 Hines Place
Dallas, Texas 75235
214/630-3540

American Lung Association
1740 Broadway
New York, New York 10019
212/245-8000

664 - Colostomies -

International Academy of Proctology
147-41 Sanford Avenue
Flushing, New York 11355
212/359-3465

American Society of Colon and Rectal Surgeons
320 W. Lafayette
Detroit, Michigan 48226
313/961-7880

*670 - Conditions of genito-urinary system -

if end stage renal failure

American Association of Genito-Urinary Surgeons
22 S. Greene Street
Baltimore, Maryland 21201
301/528-6103

American Urological Association
1120 N. Charles Street
Baltimore, Maryland 21201
301/727-1100

680 - Cleft palate and harelip with speech imperfections -

National Association of Hearing and Speech Agencies
814 Thayer Avenue
Silver Spring, Maryland 20910
301/588-5242

American Speech and Hearing Association
9030 Old Georgetown Road
Bethesda, Maryland 20014
301/530-3400

684 - Laryngectomies -

International Association of Laryngectomees
c/o American Cancer Society
219 E. 42nd Street
New York, New York 10017
212/867-3700

685 - Aphasia resulting from intracranial hemorrhage, embolism, or thrombosis (stroke) -

Academy of Aphasia
c/o Dr. Edwin A. Weinstein
Mount Sinai School of Medicine
1212 Fifth Avenue
New York, New York 10029
212/876-8323

* Included among severely disabled provided additional factor(s) pertain.

** New York Heart Association Classification as adopted by the American Heart Association.